JUNE 2003

REPORT TO THE CONGRESS

Variation and Innovation in Medicare

MEDPAC Medicare Payment Advisory Commission

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The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare+Choice program and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlet for Commission recommendations. This report describes variations in Medicare and innovations in purchasing for the program. Annual reports each March focus on payment policy. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 12, 2003

The Honorable Richard B. Cheney
President of the Senate
U.S. Capitol
Washington, DC 20510

Dear Mr. Vice President:

I am pleased to submit a copy of the Medicare Payment Advisory Commission's June 2003 Report to the Congress: Variation and Innovation in Medicare. This report fulfills MedPAC's legislative mandate to examine issues affecting the Medicare program, including the implications of changes in health care delivery for the Medicare program.

This report examines variation within expenditures, patterns of care, performance, and supplemental insurance, as well as several possible payment innovations.

- The first two chapters of this report look at variation in Medicare spending across the country and at the differing insurance markets for products that supplement Medicare.
- The next four chapters examine variation within major classes of providers, including hospitals, physicians, post-acute care providers, and dialysis facilities.
- The last three chapters investigate, and in some cases offer recommendations for, approaches Medicare could take to purchase more effectively. Ideas discussed include incentives to improve quality, competitive pricing, and alternative methods of paying for Medicare-covered drugs.
- The report includes two appendixes. One fulfills our statutory obligation to analyze the Secretary of HHS's estimate of the update for physician services. The other lays out a new feature of the June report—an agenda for improving data on Medicare and health care.

Sincerely,

Glenn Hackbarth, J.D.
Chairman

Enclosure

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June 12, 2003

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
U.S. House of Representatives
H232 Capitol Building
Washington, DC 20515

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Glenn Hackbarth, J.D.
Chairman

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Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations. We thank the staff members of the Centers for Medicare & Medicaid Services who, despite a heavy workload, were particularly helpful during preparation of the report: Sharon Arnold, Brady Augustine, Jody Blatt, Phillip Cotterill, William Cymer, Rick Foster, Pamela Frederick, Mark Freeland, Stuart Guterman, Marc Hartstein, Stephen Heffler, Peter Hickman, Linda Magno, Ann Meadow, Solomon Mussey, Kimberly Neuman, Robert Niemann, Barbara Paul, Sharman Stephens, Mark Wynn, Scott Young, and Carlos Zarabozo.

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Medicare payments for outpatient drugs under Part B

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Medicare payments for outpatient drugs under Part B

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- Reform efforts
- Lessons from other payers

This chapter looks in depth at one service—Medicare-covered outpatient drugs—for which the Medicare payment method is flawed. Three major problems are that Medicare payments far exceed provider acquisition costs; the system creates incentives for manufacturers to raise their list prices, resulting in increased Medicare payments; and drug administration fees do not reflect the true costs of providing drugs to beneficiaries.

Policymakers are considering how to change the current system. We examined payment methods that other public and private purchasers have developed for physician-administered drugs. We also analyzed the alternatives suggested by the policy community, which include benchmarking methods, payment based on invoice prices, and competitive bidding. Several variants of benchmarking methods are possible, including benchmarking payment amounts to transaction prices that could be audited. Combination approaches based on the competitiveness of the therapeutic drug class are also possible. While each method has advantages and disadvantages, any one of these alternatives would be a significant improvement over the current payment system.

Spending for outpatient drugs covered under Medicare Part B has grown rapidly. Preliminary estimates suggest that expenditures reached $8.5 billion in 2002, an increase of nearly 35 percent over 2001 totals. For the past four years, expenditures have increased annually by more than 20 percent. This growth reflects increased use of the drugs, rising prices, and incremental coverage expansions. Medicare-covered outpatient drugs are mainly used in cancer treatment, dialysis, organ transplantation, and hemophilia. Medicare also covers some outpatient drugs used with durable medical equipment such as infusion pumps and nebulizers.

Medicare pays providers 95 percent of the average wholesale price (AWP) for each covered drug. Despite its name, AWP does not represent the average wholesale price but rather can be thought of as a manufacturer's suggested list price. AWP is not defined in law or regulation and does not have to correspond to any transaction price or average transaction price. A series of studies by the General Accounting Office (GAO) and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) showed that the current Medicare payment method leads to payments that far exceed providers' costs (GAO 2001b; OIG 2001, 1997, 1996). In some cases, beneficiaries' coinsurance payments alone exceed the price physicians and other providers paid for the drugs.

This chapter describes the current payment method and looks at the potential alternatives being considered by the policy community. We examine the mix of drugs covered by Medicare and analyze trends in spending and provide an overview of the legislative and regulatory history of the payment system, including recent administrative steps taken by CMS. We focus on three problems with the payment system: Medicare payments far exceed provider acquisition costs; the system creates incentives for manufacturers to raise list prices; and high drug prices may, in part, subsidize drug administration fees, which may not reflect the true cost of providing drugs to beneficiaries.

We present some alternatives to reform the Medicare payment system, and analyze how they would affect Medicare payments for covered drugs, how likely they are to affect beneficiary access to needed therapies, what administrative costs they would entail, and how they might affect the operation of the wider pharmaceutical market. While all payment methods have advantages and disadvantages, each option analyzed would be a significant improvement over the current payment system. Most would eliminate manufacturer incentives to raise list prices. Finally, we examine payment methods developed by other public and private payers for physician-administered drugs. These methods provide additional insight into alternatives to the Medicare payment system.

Coverage and spending

Medicare spending for Part B drugs has increased rapidly in recent years, growing by 26 percent in 2001 with corresponding increases in beneficiary obligations for copayments. Beneficiaries who receive these drugs are responsible for paying 20 percent coinsurance after they meet the annual Part B $100 deductible. CMS projects that expenditures totaled $8.5 billion in 2002, an increase of nearly 35 percent.[1] Increased spending is associated with recent coverage expansions. Spending for Part B drugs is highly concentrated. The top 35 drugs accounted for almost 90 percent of drug spending and three specialties—hematology oncology, medical oncology, and urology—accounted for more than half of total billing in 2001.

Which drugs are covered?

In general, Medicare covers drugs administered in physician offices, used as part of durable medical equipment or infusion devices, as well as some oral drugs used following organ transplants. Of the top 20 drugs covered by Medicare in 2001, 7 received Food and Drug Administraton (FDA) approval in 1996 or later.

Drugs currently covered

Under Part B, Medicare covers about 450 outpatient pharmaceutical products and biologics. Spending is highly concentrated among these products. Thirty-five of the covered drugs account for 88 and 95 percent of Medicare drug spending and drug claims volume, respectively. The top 20 drugs covered under Part B are shown in Table 9-1. They accounted for about 77 percent of Part B drug expenditures; nonend-stage renal disease erythropoietin[2] alone accounted for more than 12 percent.

Not generally available through retail pharmacies, these drugs are provided by physicians in their offices or through pharmacy suppliers that provide drugs used with durable medical equipment. They include:

- drugs not self-administered and furnished incidental to a physician's service, such as prostate cancer drugs;
- certain cancer and antinausea drugs available in pill form;
- blood clotting factor;
- immunosuppressive drugs used following organ transplants;
- erythropoietin used to treat anemia in end-stage renal disease patients and cancer patients;
- drugs used as part of durable medical equipment or infusion devices like the albuterol used in nebulizers for asthma and other pulmonary diseases; and

1 Expenditure totals for 2002 are still preliminary. These totals represent carrier paid drugs and do not include intermediary paid drugs including drugs dispensed in outpatient departments of hospitals and freestanding dialysis facilities (see text box, p. 155).

2 The Congress established a separate payment rate for erythropoietin supplied to end-stage renal disease patients in dialysis facilities (see text box, p. 155).